

## **DRAFT Senate Finance Committee Chronic Care Comments**

Chronic diseases are the leading causes of death and disability in the U.S. and account for 75% of the nation's health care spending. Older adults are disproportionately affected; 80% have at least one chronic health condition, and more than half have multiple chronic conditions, which are especially difficult and costly to manage. With an aging population and unprecedented obesity rates (a risk factor for many chronic conditions), the burden of chronic disease is rapidly increasing and causing extraordinary challenges for the U.S. health care system.

Older adults with chronic conditions face a number of barriers in terms of coping with their illness and optimizing their health, which include lack of social support, low skill levels for symptom management, and low confidence in their abilities to manage their conditions (self-efficacy). Self-management is heralded as a key component in the improvement of health outcomes associated with chronic disease. According to the Institute of Medicine, self-management is defined as "the tasks that individuals must undertake to live well with one or more chronic conditions."

### The Importance of Chronic Disease Self-Management Education

Health care policymakers and practitioners have expressed continuing concern about inadequate chronic care management and treatment with the consensus that changes in primary, secondary, and tertiary care are needed to better serve this population and that health care providers should place a priority on slowing the progression of chronic disease.<sup>[1]</sup> Many strategies to improve care have been advanced, including better coordination of care and care transition among multiple care sites and providers, as well as innovative models of patient- and family-centered care. Among the strategies advanced is greater attention to the dissemination of models of chronic disease self-management education (CDSME) to more Americans through both in-person and online programs.

Despite evidence that motivated and informed patients are more likely to have better health care outcomes,<sup>[2]</sup> the health care delivery system is more oriented toward acute care than helping people to better manage the effects of chronic disease. Clinicians tend to see patients for very short periods of time, limiting their ability to discuss how lifestyles may affect their health or ways to self-manage chronic conditions. According to the CDC, many people suffer from health risk behaviors that people themselves can change, such as improved physical activity and nutrition, decreased use of tobacco and alcohol, and control of high blood pressure and cholesterol.<sup>[3]</sup> Many experts believe

that all of these issues could be addressed by helping individuals manage their symptoms. Self-management has been identified by health care experts to be one of six models that successfully improve the lives of chronically ill persons and that integrate medical and community-based care.<sup>[4]</sup> Some

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[1] Gerard Anderson, "Chronic Conditions: Making the Case of Ongoing Care."

[2] David M. Mosen *et al.*, "Is Patient Activation Associated with Outcomes of Care for Adults with Chronic Conditions?" *Journal of Ambulatory Care Management*, 30, no. 1 (2007): pp. 21–29; and Thomas Bodenheimer, Kate MacGregor, and Claire Sharifi, "Helping Patients Manage Their Chronic Conditions," prepared for the California HealthCare Foundation, June 2005, available at [www.chcf.org/documents/chronicdisease/HelpingPatientsManageTheirChronicConditions.pdf](http://www.chcf.org/documents/chronicdisease/HelpingPatientsManageTheirChronicConditions.pdf)

[3] CDC, "Chronic Disease and Health Promotion." <http://www.cdc.gov/chronicdisease/overview/index.htm#sec3>

[4] Chad Boulton and Erin K. Murphy, "New Models of Comprehensive Health, Care for People with Chronic Conditions," in Institute of Medicine. *Living Well with Chronic Illness: A Call for Public Health Action*, January 31, 2012. The other models were: transitional care, caregiver education and support, interdisciplinary primary care. Care management, and geriatric evaluation and management. <http://www.iom.edu/Reports/2012/Living-Well-with-Chronic-Illness.aspx>